HOUSTON HEALTH DEPARTMENT

CONSENT FOR MEDICAL TREATMENT OF MINOR RECEIVING CONTRACEPTION

Minor Patient's information. All references to "Minor Patient" in this Consent refer to the patient named below.

Full name:
DOB/Age:
MR#:

SECTION A: CONSENT BY PARENT, MANAGING CONSERVATOR, GUARDIAN, OR OTHER ADULT

I am the (check one):

❑ Parent of the Minor Patient.

❑ Managing conservator of the Minor Patient.

❑ Guardian of the Minor Patient. Proof of guardianship is required.

❑ Other (if the parent, managing conservator, or guardian CANNOT BE CONTACTED, complete section below)

_____

Printed Names of Parent(s)/Managing Conservator, Guardian, or Other Adult

Complete this section only if the parent, managing conservator, or guardian CANNOT BE CONTACTED

The person having the right to consent to medical treatment for the Minor Patient (parent/managing conservator/guardian) cannot be contacted and has not given notice to the contrary.

The name of one or both parent(s)/ guardian that cannot be contacted is/are:

_____

As per Texas Family Code Chapter 32.001, I may consent for medical treatment of the Minor Patient. I am the (select one):

❑ Grandparent

❑ Adult brother or sister of the Minor Patient

❑ Adult aunt or uncle of the Minor Patient

❑ Adult responsible for Minor Patient under juvenile court order

❑ Educational institution with authorization to consent from a person having the right to consent

❑ Adult with care/control/possession with written authorization to consent from the person having the right to consent

❑ Law enforcement officer with custody of a minor in need of immediate medical treatment

❑ Texas Youth Commission staff

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I consent to The City of Houston Health Department providing to Minor Patient confidential medical treatment regarding appropriate evaluation, testing, and treatment relating to contraception (including a birth control drug, device, or Early Contraception ("EC") (e.g., Plan B) and other levonorgestrel-containing ECs). I further consent to permitting the Minor Patient to give informed consent for the contraception method of his/her choice as part of the confidential medical treatment and waive my right to review and sign a consent form for the contraception method the Minor Patient chooses. The Minor Patient will be provided a fact sheet by the City of Houston Health Department that lists risks, benefits, and alternatives to the contraception method or another medical service. The Minor Patient will have a chance to review the fact sheet and will be provided an opportunity to ask questions regarding the recommended contraception method or other medical services I understand that if tests for certain sexually transmitted infections are positive, reporting positive results to public health agencies is required by law, and the City of Houston Health Department will refer the positive result. The Minor Patient may be given referrals for further diagnosis or treatment, if necessary. I understand that if a referral is needed, it is my responsibility to obtain and pay for this medical care. The Minor Patient will be told how to get care in case of an emergency. No guarantee has been given to me as to the results that may be obtained from any medical services the Minor Patient may receive from the City of Houston Health Department.

I consent to the use and disclosure of the Minor Patient's health information as described in the City of Houston Health Department Notice of Privacy Practices and consent to the Minor Patient to access and/or obtain copies of his/her health information without my consent and as described in the City of Houston Health Department's Notice of Privacy Practices. The Minor Patient will receive a copy of the Notice of Privacy Practices and sign an attestation acknowledging the Minor Patient received it. I understand that the Minor Patient has the right to receive free language interpreter services as described in the Non-Discrimination Notice the Minor Patient will receive. I am aware that the Minor Patient's confidentiality may be broken if the City of Houston Health Department cannot contact him/her if an abnormal test result is received or a life-threatening condition is suspected or detected.

This consent begins on the date below and remains in effect unless revoked in writing. Any revocation of this consent is not effective with respect to medical treatment, including contraception, already provided, or any actions were taken by the City of Houston Health Department Name in reliance on this consent.

I declare under penalty of perjury that the above information is true and correct.

_____	_____	_____
Printed Name of Person Giving Consent	Signature	Date
_____	_____	_____
Staff Printed Name	Signature	Date

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SECTION B: CONSENT BY MINOR PATIENT

I am (check one):

❑ A married minor.

❑ An emancipated minor.

❑ Age 16 or older, living separate and apart from my parents, managing conservator, and/or guardian, and manage my own financial affairs.

❑ A minor who is unmarried and the parent of a minor. I have custody of this minor and I am able to provide consent to the medical care for my minor. I understand that I cannot consent for my own treatment, only the treatment of my minor child.

I declare under penalty of perjury that the above information is true and correct.

Printed Name of Minor Patient Signature and Date

_____

Witness Printed Name Signature and Date

_____